

School Name & Address:

Grade: _____



STATE OF RHODE ISLAND SCHOOL PHYSICAL FORM

Health Care Provider Name and Address:

Phone: _____

This form may substitute for any district-issued form. All districts must accept this form. General health examinations shall be documented in a standardized format with one copy available from the Rhode Island Department of Health or in any such format that captures the same fields of information (R16-21SCHO Section 8.4)

Student Name: Last		First		Middle	Date of Birth	Sex
Address: Street		Apt #	City	State	Zip Code	Home Phone

PLEASE COMPLETE ALL INFORMATION BELOW (May attach immunization transcript).

IMMUNIZATIONS Please enter dates in MM/DD/YYYY format

Hepatitis B					
Diphtheria-Tetanus-Pertussis DTaP < 7 years					
Pneumococcal Conjugate PCV					
Polio					
Haemophilus Influenzae Type B Hib					
Measles-Mumps-Rubella MMR					
Varicella					
Tetanus-Diphtheria-Pertussis Tdap/Td > 7 years					
Rotavirus					
Hepatitis A					
Meningococcal					
HPV					
Influenza					

☐ Student has history of varicella disease

Medical Exemption:

☐ Hep B ☐ DTaP ☐ PCV ☐ Polio ☐ Hib ☐ MMR ☐ Varicella ☐ Td/Tdap ☐ Rotavirus ☐ Hep A ☐ Mening ☐ HPV ☐ Influenza

PHYSICAL EXAMINATION

Date of PE ____/____/____

Height _____

Weight _____

BP _____

PLEASE NOTE ANY HEALTH PROBLEM, CHRONIC HEALTH CONDITION OR DISABILITY THAT MAY AFFECT BEHAVIOR OR HEALTH AT SCHOOL:

1. ASTHMA: No ☐ Yes ☐ If yes, complete an Asthma Action Plan (www.health.ri.gov/publications/actionplans/2012Asthma.pdf)2. ALLERGIES: No ☐ Yes ☐ (Please explain) _____ EPINEPHRINE AUTO-INJECTOR REQUIRED: No ☐ Yes ☐If student has a severe allergy (food, insect, other) complete a Food Allergy & Anaphylaxis Emergency Care Plan (www.foodallergy.org/document.doc?id=234)3. DIABETES: No ☐ Yes ☐ If yes, complete a Physicians Order Form For Students With Diabetes (www.health.ri.gov/forms/school/PhysicianOrdersForStudentsWithDiabetes.pdf)

4. OTHER: _____

Treatment Plan: _____

RESTRICTIONS: Can participate in physical education/sports: Fully ☐ With limitation ☐MEDICATION (REQUIRED AT SCHOOL): No ☐ Yes ☐ (Please list) _____

Other medication(s) that may affect behavior or health at school: _____

LEAD SCREENING (Required for children < 6 years old)

Student is in compliance with lead screening requirements:

Yes ☐ No ☐

SCOLIOSIS SCREENING

Yes ☐ No ☐

VISION SCREENING (Children entering Kindergarten)

☐ Passed Screening ☐ Screened & referred for comprehensive exam☐ Referred for comprehensive exam, but not screened

TUBERCULOSIS (If required by school district)

Date of TB test: _____

Screening / Referral

Date: _____

Comprehensive

Exam Date: _____

HEALTH CARE PROVIDER SIGNATURE: _____

DATE: _____

PRINT NAME: _____